

# VIRGINIA ADVANCE MEDICAL DIRECTIVE

I \_\_\_\_\_, intentionally and voluntarily make known my wishes in the event that I am incapable of making an informed decision, as follows:

- YOU MAY INCLUDE IN THIS ADVANCE DIRECTIVE ANY OR ALL SECTIONS I THROUGH V BELOW
- BE SURE TO CROSS THROUGH AND INITIAL ANY SECTION(S) YOU DO NOT WISH TO INCLUDE

**SECTION I: APPOINTMENT OF AGENT** - Cross through Section I & II if you do not wish to appoint an agent

I hereby appoint the following as my primary agent to make health care decisions on my behalf as authorized in this document:

_____	_____	_____
Print Full Name of Primary Agent	Telephone	Alternate number
_____		_____
Address		Email Address

If the above named primary agent is not reasonably available or is unable or unwilling to act as my agent, then I appoint the following as my successor agent:

_____	_____	_____
Print Full Name of Primary Agent	Telephone	Alternate number
_____		_____
Address		Email Address

I hereby grant to my agent named above full power and authority to make health care decisions on my behalf as described below whenever I have been determined to be incapable of making an informed decision. My agent's authority is effective as long as I am incapable of making an informed decision.

In exercising the power to make health care decisions on my behalf, my agent shall follow my desires and preferences as stated in this document or as otherwise known to my agent. My agent shall be guided by my medical diagnosis and prognosis and any information provided by my physicians as to the intrusiveness, pain, risks, and side effects associated with treatment or non-treatment. My agent shall not make any decision regarding my health care which he or she knows, or upon reasonable inquiry ought to know, is contrary to my religious beliefs or my basic values, whether expressed orally or in writing. If any agent cannot determine what health care choice I would have made on my own behalf, then my agent shall make a choice for me based upon what he or she believes to be in my best interest.

My agent shall not be liable for the costs of health care that he or she authorizes, based solely on that authorization.

## SECTION II: POWERS OF MY AGENT

**The powers of my agent shall include the following:** (Please check the boxes you agree with)

**A.** To consent to refuse or withdraw consent to any type of health care, treatment, surgical procedure, diagnostic procedure, medication and the use of mechanical or other procedures that affect any bodily function, including, but not limited to, artificial respiration, artificially administered nutrition and hydration, and cardiopulmonary resuscitation. The authorization specifically includes the power to consent to the administration of dosages of pain-relieving medication in excess of recommended dosages in an amount sufficient to relieve pain, even if such medication carries the risk of addiction or of inadvertently hastening my death.

*My agent's authority under this Subsection A shall be limited by any specific instructions I give in Section IV below regarding my health care.*

**B.** To request, receive and review any oral or written information regarding my physical or mental health, including but not limited to medical and hospital records, and to consent to the disclosure of this information.

**C.** To employ and discharge my health care providers.

**D.** To authorize my admission to or discharge (including transfer to another facility) from any hospital, hospice, nursing home, assisted living facility or other medical care facility (*If I have authorized admission to a health care facility for treatment of mental illness, that authority is stated in the Mental Health Care Supplement form Sub-Sections E., F., G., & H enclosed in the information packet folder*)

**I.** To authorize my participation in any health care study approved by an institutional review board or research review committee pursuant to applicable federal or state law: (*check one or both of the following*)

If the study offers the prospect of direct therapeutic benefit to me.

If the study aims to increase scientific understanding of any condition that I may have or otherwise promote human well-being, even though the study offers no prospect of direct benefit to me.

**J.** To make decisions regarding visitation during any time that I am admitted to any health care facility, consistent with the following directions:

No Restrictions       My Restrictions are:

*Please define your restrictions:*

**K.** To make any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

## SECTION III: INSTRUCTIONS ABOUT END OF LIFE CARE ("LIVING WILL")

If at any time my attending physician should determine that I have a **terminal condition** where the application of **life prolonging procedures**-including **artificial respiration**, **cardiopulmonary resuscitation**, **artificially administered nutrition** and or **hydration** would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

*In the absence of my ability to give directions regarding the use of such life-prolonging procedures, it is my intention that this advance directive shall be honored by my family and physician as the final expression of my legal right to refuse health care and my acceptance of the consequences of such refusal.*

CHECK HERE IF YOU WANT THIS

Initial \_\_\_\_\_

CHECK HERE IF YOU DON'T WANT THIS

Initial \_\_\_\_\_ (Please cross through this section)

## SECTION IV: HEALTH CARE INSTRUCTIONS

If you wish to provide your own directions about **life-prolonging procedures**, or if you wish to add to the directions already given, you may do so in this Section. If you wish to give specific instructions regarding certain life-prolonging procedures, such as artificial respiration, cardiopulmonary resuscitation, artificially administered nutrition and/or hydration, this is where you should note such preferences.

Cross through any of the language if your specific instructions that follow are different.

**My instructions about life prolonging treatment: (Initial only ONE box in this section)**

If it is reasonably certain that I will not recover my ability to be aware of myself or others or to interact with others, I want to stop or withhold **all** treatments that might prolong my existence. Treatments I would not want include tube feedings, IV fluids, CPR, respirator (breathing machine), kidney dialysis, antibiotics.

I choose to continue treatment. I want all treatments to prolong my life as long as possible within the limits of generally accepted health care standards. *(If you choose this option, please cross through and initial the Living Will portion above to avoid confusion about your instructions.)* OR

I choose to provide no written guidelines, directing my agent to make decisions based on my known values and wishes.

**My instructions about pain and symptom control: (Initial only ONE box in this section)**

I want pain medicine and symptom treatments to keep me comfortable, even if it means I am unable to interact with others. I want treatment for such things as shortness of breath, agitation, and seizures.

I want symptom control and pain relief as follows:

I direct that: \_\_\_\_\_

I choose to provide no written guidelines, directing my agent to make decisions based on my known values and wishes.

I specifically direct that I receive the following health care if it is medically appropriate under the circumstances as directed by my physician:

I direct that: \_\_\_\_\_

I specifically direct that the following health care **NOT** be provided to me under the following circumstances: (You may also specify that certain health care **NOT** be provided under any circumstances.)

I direct that: \_\_\_\_\_

**DIRECTIONS ABOUT CARE OTHER THAN LIFE-PROLONGING PROCEDURES.** (You may give any other instructions about your care if you have a terminal condition aside from your instructions about life-prolonging procedures:

I direct that: \_\_\_\_\_

**SECTION V: APPOINTMENT OF AN AGENT TO MAKE AN ANATOMICAL GIFT OR ORGAN, TISSUE OR EYE DONATION**

**(CROSS THROUGH THIS SECTION V IF YOU DO NOT WANT TO APPOINT AN AGENT TO MAKE AN ANATOMICAL GIFT OR ANY ORGAN, TISSUE OR EYE DONATION FOR YOU)**

Upon my death, I direct that an anatomical gift of all of my body or certain organ, tissue or eye donations may be made pursuant to Article 2 (§32.1-289.2 et seq.) of Chapter 8 of Title 32.1 of the Code of Virginia and in accordance with my directions below, if any. I hereby appoint the following as my agent to make any such anatomical gift or organ, tissue or eye donation following my death.

\_\_\_\_\_  
Print Full Name of Designated Agent

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Address

\_\_\_\_\_  
Alternate Phone Number

\_\_\_\_\_  
Email Address

**I further direct that:** (Declarant's directions, if any, concerning donation): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**AFFIRMATION AND RIGHT TO REVOKE:**

**(YOU MUST SIGN BELOW IN THE PRESENCE OF TWO WITNESSES)**

By signing below, I state that I am emotionally and mentally capable of making this advance directive that I understand the purpose and effect of this document. I understand that I may revoke all or any part of this document at any time (i) with a signed, dated writing; (ii) by physical cancellation or destruction of this advance directive by myself or by directing someone else to destroy it in my present; or (iii) by my oral expression of intent to revoke.

\_\_\_\_\_  
Signature of Declarant

\_\_\_\_\_  
Print Full Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date

**CHECK HERE IF THE MENTAL HEALTH SUPPLEMENT FORM WAS COMPLETED**

**Under penalty of perjury I, Witness to the Declarant, verify that I am over the age of 18, and I am not appointed as an agent on the Declarant's behalf, and the Declarant has signed the forgoing advance directive in my presence.**

\_\_\_\_\_  
Witness 1 Signature

\_\_\_\_\_  
Witness 2 Signature

\_\_\_\_\_  
Witness 1 Signature

\_\_\_\_\_  
Witness 2 Signature

# VIRGINIA ADVANCE DIRECTIVE MENTAL HEALTH CARE SUPPLEMENT

I, \_\_\_\_\_, (please print your name and check individual sections as appropriate)

## SECTION II: DESIGNATE THE FOLLOWING POWERS TO A HEALTH CARE AGENT

**E.** To authorize my admission to a health care facility for the treatment of mental illness for no more than 10 calendar days provided that **I do not protest** the admission and provided that a physician on the staff designated by the proposed admitting facility examines me and states in writing that I have a mental illness, that I am incapable of making an informed decision about my admission and that I need treatment in the facility; and to authorize my discharge (including transfer to another facility) from the facility.

**F.** To authorize my admission to a health care facility for the treatment of mental illness for no more than 10 calendar days, **even if I protest**, if a physician on the staff of or designation by the proposed admitting facility examines me and states in writing that I have a mental illness that I am incapable of making an informed decision about my admission, and that I need treatment in the facility; and to authorize my discharge (including transfer to another facility) from the facility.

☛ *If you give your agent the powers described in Section F, your physician must complete the following attestation*

**Physician attestation:** I am the physician or licensed clinical psychologist of the Declarant of this advance directive. I hereby attest that I believe the Declarant to be presently capable of making an informed decision and that the Declarant understands the consequences of this provision of this advance directive.

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Name Printed

\_\_\_\_\_  
Name of Practice

\_\_\_\_\_  
Phone Number

**G.** To authorize the following specific types of health care identified in this advance directive **even if I protest** (*Specifically cross-reference any applicable sections of this advance directive*).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☛ *If you give your agent the powers described above in Section G and below in Section H your physician must complete the following attestation.*

**Physician attestation:** I am the physician or licensed clinical psychologist of the Declarant of this advance directive. I hereby attest that I believe the Declarant to be presently capable of making an informed decision and that the Declarant understands the consequences of this provision of this advance directive.

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Name Printed

\_\_\_\_\_  
Name of Practice

\_\_\_\_\_  
Phone Number

**H.** To continue to serve as my agent even if I protest the agent's authority after I have been determined to be incapable of making an informed decision.

\_\_\_\_\_  
SIGNATURE OF DECLARANT

\_\_\_\_\_  
PRINT FULL NAME

\_\_\_\_\_  
DATE OF BIRTH

\_\_\_\_\_  
SOCIAL SECURITY NUMBER

\_\_\_\_\_  
DATE